University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper I

TRUST BOARD – 5th MARCH 2015

QUALITY AND PERFORMANCE REPORT – JANUARY 2015

DIRECTOR:	Rachel Overfield, Chief Nurse Kevin Harris, Medical Director Richard Mitchell, Chief Operating Officer Emma Stevens, Acting Director of Human Resources
AUTHOR:	
DATE:	5th March 2015
PURPOSE:	The following report provides an overview of the January Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required. It includes a Chief Executive's summary of key issues.
PREVIOUSLY CONSIDERED BY:	**Integrated Finance, Performance and Investment Committee** **Quality Assurance Committee**
Objective(s) to which issue relates *	[X] 1. Safe, high quality, patient-centred healthcare [X] 2. An effective, joined up emergency care system [X] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [X] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [X] 5. Enhanced reputation in research, innovation and clinical education [X] 6. Delivering services through a caring, professional, passionate and valued workforce [X] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	
Organisational Risk Register/ Board Assurance Framework *	[X] **Organisational Risk Register** [X] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [ ] For assurance [X] For information [ ]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

CHIEF EXECUTIVE'S ISSUES TO HIGHLIGHT REPORT

Exception reports are automatically triggered when pre-set national or local thresholds are met. The issues that I wish to particularly highlight/comment on for January are as follows:

Clostridium Difficile (page 10)
In January we were back on trajectory for our national targets and we remain on course to deliver the national target. NHS England have recently released 15/16 trajectories for Acute Trusts with the UHL's trajectory confirmed as 61. There remain significant discussions with Interserve on the quality of cleaning. This continues to be managed as part of the contract process.

Never Events (page 11)
The Never Event reported in January was one of the two cases reported in the December Q&P and is not a new Never Event. Follow up of these events will take place at both EQB and QAC, so as to minimise the chances of a recurrence.

Maternal Deaths (page 12)
There was an unexpected indirect maternal death in January reported to the Coroner, but an inquest was not required. A decision was made by the CCG that an RCA investigation was not required as there were no omissions or mismanagement in care that led to the indirect maternal death.

Fractured Neck of Femur (page 17)
It is disappointing that we are not seeing any improvement in this key quality metric with performance below trajectory for the last 6 months. The Listening into Action group is now underway.

RTT Admitted (page 19)
It is encouraging to see that RTT backlog (18+ week waiters) continues to improve and that we are delivering 2 out of the 3 RTT targets. Backlog trajectories for both admitted and non-admitted patients have been signed off with the TDA and commissioners. Risks and mitigation plans are included in the exception report with delivery of admitted performance still expected April 2015.

Diagnostic waits (page 20)
Performance was very disappointing for a second month with a further deterioration in performance to 5%.Areas that contributed to this poor performance include MRI, Endoscopy, and Sleep studies due to insufficient capacity plus Dexa Scans due to a system failure. Action has been taken to resolve these issues and the good news is that the February position is looking much better with performance expected to be below the threshold of 1%.

Cancer (page 21)
It's encouraging to see that the two week wait standard was met in December. We still have work to do on the 31 day target (which is failing due to Urology) but this is now improving. A recovery plan for 62 day target has been submitted to the CCGs with the plan to recover monthly performance in July and cumulative performance by September.

John Adler
Chief Executive

Caring at its best

University Hospitals of Leicester NHS
NHS Trust

Quality and Performance Report

January 2015

One team shared values

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **5th MARCH 2015**

REPORT BY: **RACHEL OVERFIELD, CHIEF NURSE**
KEVIN HARRIS, MEDICAL DIRECTOR
RICHARD MITCHELL, CHIEF OPERATING OFFICER
EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES

SUBJECT: **JANUARY 2015 QUALITY & PERFORMANCE SUMMARY REPORT**

1.0 Introduction

The following report provides an overview of the January 2015 Quality & Performance report highlighting NTDA/UHL key metrics and escalation reports where required.

2.0 Performance Summary

Domain	Page Number	Number of Indicators	Indicators with target to be confirmed	Number of Red Indicators this month
Safe	3	19	2	3
Caring	4	15	1	2
Well Led	5	14	7	2
Effective	6	17	0	2
Responsive	7	26	0	14
Research	8	13	0	3
Estates & Facilities	9	10	0	0
Total		114	10	26

Safe | Caring | Well Led | Effective | Responsive | Research | Estates and Facilities

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Safe	S1a	Clostridium Difficile	RO	DJ	FYE = 81	NTDA	Red / ER for Non compliance with cumulative target	66	10	0	4	4	6	5	7	2	5	7	7	11	7	61
	S1b	Clostridium Difficile (Local Target)	RO	DJ	FYE = 50	UHL	Red >5 per month, ER when YTD red	66	10	0	4	4	6	5	7	2	5	7	7	11	7	61
	S2a	MRSA Bacteraemias (All)	RO	DJ	0	NTDA	Red = >0 ER = 2 consecutive mths >0	3	0	0	0	0	0	0	0	0	1	1	0	2	0	4
	S2b	MRSA Bacteraemias (Avoidable)	RO	DJ	0	UHL	Red = >0 ER = 2 consecutive mths >0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	S3	Never Events	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	3	0	1	0	0	0	0	0	0	0	1	0	1	1	3
	S4	Serious Incidents	RO	MD	tbc	NTDA	tbc	60	3	4	5	4	6	3	7	2	3	4	2	4	3	38
	S5	Proportion of reported safety incidents that are harmful	RO	MD	tbc	NTDA	tbc	2.8%	2.3%			1.7%			2.2%			1.4%				1.8%
	S6	Overdue CAS alerts	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	2	0	0	0	2	2	2	3	0	0	0	0	0	0	9
	S7	RIDDOR - Serious Staff Injuries	RO	MD	FYE = <47	UHL	Red / ER = non compliance with cumulative target	47	7	2	5	3	5	1	2	2	1	2	2	1	0	19
	S8	Safety Thermometer % of harm free care (all)	RO	EM	tbc	NTDA	Red = <92% ER = in mth <92%	93.6%	93.8%	94.8%	93.6%	94.6%	94.7%	94.2%	94.9%	94.4%	93.9%	94.9%	93.3%	94.1%	95.0%	94.4%
	S9	% of all adults who have had VTE risk assessment on adm to hosp	KH	SH	95% or above	NTDA	Red = <95% ER = in mth <95%	95.3%	95.6%	95.0%	95.6%	95.7%	95.9%	95.9%	96.3%	95.5%	96.2%	95.4%	95.5%	95.0%	96.3%	95.8%
	S10	Medication errors causing serious harm	RO	MD	0	NTDA	Red = >0 in mth ER = in mth >0	New NTDA Indicator - Definition to be confirmed														
	S11	All falls reported per 1000 bed stays for patients >65years	RO	EM	<7.1	QC	Red >= YTD >8.4 ER = 2 consecutive reds	7.1	6.6	7.0	6.9	7.0	7.5	7.1	7.3	7.3	5.9	6.4	7.5	6.9	7.1	7.0
	S12	Avoidable Pressure Ulcers - Grade 4	RO	EM	0	QS	Red / ER = Non compliance with monthly target	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	S13	Avoidable Pressure Ulcers - Grade 3	RO	EM	<8 a month	QS	Red / ER = Non compliance with monthly target	71	7	3	6	5	5	5	5	6	6	4	6	7	5	54
	S14	Avoidable Pressure Ulcers - Grade 2	RO	EM	<10 a month	QS	Red / ER = Non compliance with monthly target	120	10	8	9	6	6	6	7	9	4	8	13	11	7	77
	S15	Compliance with the SEPSIS6 Care Bundle	RO	MD	All 6 >75% by Q4	QC	Red/ER = Non compliance with Quarterly target	27.0%	27.0%			47.0%			>=60%			Audit underway				47.0%
	S16	Nutrition and Hydration Metrics - Fluid Balance and Nutritional Assessment	RO	MD	Q2 80%, Q3 85%, Q4 90%	QC	Red >2% below threshold ER = 2 mths red					≥71%	≥77%	≥75%	Action Planning	≥74%	≥85%	≥84%	≥88%	≥86%		≥86%
	S17	Maternal Deaths	KH	IS	0	UHL	Red / ER = Non compliance with monthly target	3	1	2	0	0	0	0	0	0	0	0	0	0	1	1

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Caring	C1a	Inpatient Friends and Family Test - Score	RO	CR	72 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	68.8	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	72.2
	C1b	Inpatient Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=69.9 Green >74.9	68.8	71.8	69.0	69.9	69.6	71.0	74.5	73.8	73.8	76.1	71.1	70.3	72.1	70.8	72.2
	C2a	A&E Friends and Family Test - Score	RO	CR	54 (Eng Avge - Mar 14)	NTDA	Red if <3SD. ER if <3SD or 3 mths deteriorating performance	58.5	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	68.9
	C2b	A&E Friends and Family Test - Score (Local Target)	RO	CR	75	UHL	Red/ ER =<=64.9 Green >74.9	58.5	67.6	58.7	65.5	69.4	66.0	71.4	71.7	56.3	66.1	71.1	72.3	72.8	72.4	68.9
	C3	Outpatients Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=64.9	New Indicator											58.7	69.5	75.9	72.8
	C4	Daycase Friends and Family Test - Score	RO	CR	75	UHL	Red / ER =<=69.9	New Indicator				79.0	80.2	79.7	77.5	74.3	81.7	80.1	80.9	74.9	78.5	78.7
	C5	Maternity Friends and Family Test - Score	RO	CR	75	UHL	Red/ ER =<=61.9	64.3	67.3	62.1	66.7	61.2	63.5	69.5	69.7	67.3	63.0	64.1	67.7	63.8	74.5	66.5
	C6	Complaints Rate per 100 bed days	RO	MD	tbc	NTDA	tbc		0.3	0.5	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.4
	C7	Complaints Re-Opened Rate	RO	MD	<9%	UHL	Red = >10% ER = 3 mths Red or any month >15%	New Indicator for 14/15				8%	5%	8%	11%	10%	9%	11%	11%	10%	17%	10%
	C8	Single Sex Accommodation Breaches (patients affected)	RO	CR	0	NTDA	Red = >0 ER = in mth >0	2	0	0	0	4	3	0	0	0	0	0	5	0	1	13
	C9	Improvements in the FFT scores for Older People (65+ year)	RO	CR	75	QC	Red / ER = End of Yr Targets non recoverable.	New Indicators for 14/15				73.7	73.2	75.7	76.1	78.5	83.0	76.4	72.9	76.7	76.6	76.2
	C10	Responsiveness and Involvement Care (Average score)	RO	CR	0.8 improvement	QC	tbc					87.6	87.5	87.5	87.8	88.1	88.4	87.4	87.9	87.8	88.5	88.1
	C10a	Q15. When you used the call button, was the amount of time it took for staff to respond generally:	RO	CR	FYE 89.7	QC	Red = <87.9 ER = Red or 3 mths deterioration					88.9	89.3	88.8	89.0	88.9	90.0	88.4	88.6	89.2	88.7	89.0
	C10b	Q16. If you needed help from staff getting to the bathroom or toilet or using a bedpan, did you get help in an acceptable amount of time?	RO	CR	FYE 92.9	QC	Red = <91.1 ER = Red or 3 mths deterioration					92.1	91.9	91.2	91.7	91.9	92.4	92.2	92.4	92.1	92.7	92.3
	C10c	Q11. Were you involved as much as you wanted in decisions about your care and treatment?	RO	CR	FYE 85.5	QC	Red = <83.6 ER = Red or 3 mths deterioration					84.6	84.3	84.9	84.9	85.6	85.2	84.6	85.1	84.8	86.1	85.3

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Well Led	W1	Inpatient Friends and Family Test - Coverage	RO	CR	30% - Q4. 40% Mar 15	NTDA / CQUIN	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	24.3%	24.5%	28.2%	28.8%	36.8%	38.1%	32.6%	30.8%	28.9%	33.4%	36.3%	36.0%	31.9%	34.6%	33.8%
	W2	A&E Friends and Family Test - Coverage	RO	CR	15% Q1-Q3 20% for Q4	NTDA	Red = Non compliance with monthly target ER = 2 consecutive mths non compliance	14.9%	15.6%	18.4%	16.1%	15.2%	17.8%	14.9%	10.2%	16.1%	19.1%	15.9%	14.0%	18.7%	25.3%	16.7%
	W3	Outpatients Friends and Family Test - Valid responses	RO	CR	tbc	UHL	tbc	New Indicator available from October 2014			271	175	286	1,879	1,535	785	927	1,255	1,506	1,053	1,259	10,660
	W4	Maternity Friends and Family Test - Coverage	RO	CR	tbc	UHL	tbc	25.2%	20.9%	23.7%	23.9%	27.2%	36.4%	25.2%	29.2%	29.9%	18.7%	15.8%	21.7%	22.1%	25.8%	25.2%
	W5	Friends & Family staff survey: % of staff who would recommend the trust as place to work	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed				53.6%			53.7%			Q3 staff FFT not completed as National Survey carried out				53.7%
	W6	Friends & Family staff survey: % of staff who would recommend the trust as place to receive treatment	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed				68.3%			67.2%			Q3 staff FFT not completed as National Survey carried out				67.2%
	W7	Data quality of trust returns to HSCIC	KS	JR	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W8	Turnover Rate	ES	ES	<10.5%	UHL	Red = 11% or above ER = Red for 3 Consecutive Mths	10.0%	10.6%	10.4%	10.0%	9.9%	10.0%	10.2%	10.0%	10.5%	10.3%	10.8%	10.7%	10.3%	10.1%	10.1%
	W9	Sickness absence	ES	ES	> 3.0%	UHL	Red = >3.5% ER = 3 consecutive mths >3.5%	3.4%	3.8%	3.7%	3.5%	3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.8%		3.7%
	W10	Total trust vacancy rate	ES	ES	tbc	NTDA	tbc	New NTDA Indicator - Definition to be confirmed														
	W11	Temporary costs and overtime as a % of total paybill	ES	ES	tbc	NTDA	tbc	New Indicator for 14/15				9.4%	9.4%	8.1%	8.5%	8.9%	8.5%	9.5%	9.0%	9.8%	10.5%	9.2%
	W12	% of Staff with Annual Appraisal	ES	ES	95%	UHL	Red = <90% ER = 3 consecutive mths <90%	91.3%	91.9%	92.3%	91.3%	91.8%	91.0%	90.6%	89.6%	88.6%	89.7%	91.8%	92.3%	92.5%	90.9%	90.9%
	W13	Statutory and Mandatory Training	ES	ES	Jun 80%, Sep 85%, Dec 90%, Mar 95%	UHL	Red / ER for Non compliance with Quarterly incremental target	76%	69%	72%	76%	78%	79%	79%	80%	83%	85%	86%	87%	89%	89%	89%
	W14	% Corporate Induction attendance	ES	ES	95.0%	UHL	Red = <90% ER = 3 consecutive mths <90%	94.5%	93%	89%	95%	96%	94%	92%	96%	98%	98%	98%	98%	100%	99%	99%

	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Effective	E1	Mortality - Published SHMI	KH	PR	Within Expected	NTDA	Higher than Expected		107 (Jul12-Jun13)			106 (Oct12-Sept13)			106 (Jan13-Dec13)			105 (Apr13-Mar14)			105 (Jul13-Jun14)	105 (Jul13-Jun14)
	E2	Mortality - Rolling 12 mths SHMI (as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive mths increasing SHMI >100	105	107	106	105	104	105	105	104	103	102	Awaiting HED Update				102
	E3	Mortality HSMR (DFI Quarterly)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	88	83			92			87			86	Awaiting HED Update			89
	E4	Mortality - Rolling 12 mths HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	100	100	99	97	98	98	97	96	96	96	Awaiting HED Update			96
	E5	Mortality - Monthly HSMR (Rebased Monthly as reported in HED)	KH	PR	100 or below	QC	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	91	89	103	91	83	110	107	87	99	98	92	Awaiting HED Update			97
	E6	Mortality - Rolling 12 mths HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	101	101	100	99	99	100	98	97	97	96	Awaiting HED Update			96
	E7	Mortality - Monthly HSMR Emergency Weekday Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	100	93	102	94	88	100	111	86	91	99	90	Awaiting HED Update			95
	E8	Mortality - rolling 12 mths HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	101	102	99	95	98	97	97	97	97	98	Awaiting HED Update			98
	E9	Mortality - Monthly HSMR Emergency Weekend Admissions - (HED) OVERALL Rebased Monthly	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	99	84	106	82	69	137	94	94	122	99	106	Awaiting HED Update			103
	E10	Deaths in low risk conditions (Risk Score)	KH	PR	Within Expected	NTDA	Red = >expected ER = >Expected or 3 consecutive increasing mths >100	94	164	35	63	63	80	103	78	62	57	92	Awaiting HED Update			77
	E11	Emergency 30 Day Readmissions (No Exclusions)	KH	PR	Within Expected	NTDA	Higher than Expected	7.9%	8.7%	9.0%	8.8%	8.8%	8.8%	8.6%	8.4%	8.9%	8.4%	8.7%	8.9%	9.1%		8.7%
	E12	No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions	KH	RP	72% or above	QS	Red = <72% ER = 2 consecutive mths <72%	65.2%	68.2%	73.7%	54.7%	56.9%	40.6%	60.3%	76.9%	59.0%	68.6%	69.6%	59.4%	57.3%	57.9%	60.9%
	E13	Stroke - 90% of Stay on a Stroke Unit	RM	CF	80% or above	QS	Red = <80% ER = 2 consecutive mths <80%	83.2%	89.3%	83.7%	83.5%	92.9%	80.3%	87.1%	78.1%	84.5%	83.2%	70.4%	72.1%	75.2%		80.0%
	E14	Stroke - TIA Clinic within 24 Hours (Suspected High Risk TIA)	RM	CF	60% or above	QS	Red = <60% ER = 2 consecutive mths <60%	64.2%	60.5%	40.7%	77.9%	79.7%	58.8%	71.3%	62.8%	65.5%	72.7%	67.8%	69.0%	83.5%	80.6%	71.4%
	E15	Communication - ED, Discharge and Outpatient Letters - Compliance with standards	KH	SJ	90% or above	QS	Red = <80% ER = Qrtly ER if <90% and deterioration	New Indicator for 14/15								60% (InPt)	83% (ED)	Policy out for consultation				83% (ED)
	E16	Published Consultant Level Outcomes	KH	SH	>0 outside expected	QC	Red = >0 Quarterly ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E17	Non compliance with 14/15 published NICE guidance	KH	SH	0	QC	Red = in mth >0 ER = 2 consecutive mths Red	New Indicator for 14/15				0	0	0	0	0	0	0	0	0	0	0

Responsive

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	13/14 Outturn	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
R1	ED 4 Hour Waits UHL + UCC (Sit Rep)	RM	CF	95% or above	NTDA	Red = <95% ER via ED TB report	88.4%	93.6%	83.5%	89.3%	86.9%	83.4%	91.3%	92.5%	90.9%	91.5%	90.1%	88.5%	83.0%	90.2%	88.8%
R2	12 hour trolley waits in A&E	RM	CF	0	NTDA	Red = >0 ER via ED TB report	5	0	0	0	0	1	1	0	0	0	1	0	0	1	4
R3	RTT Waiting Times - Admitted	RM	CC	90% or above	NTDA	Red /ER = <90%	76.7%	81.8%	79.1%	76.7%	78.9%	79.4%	79.0%	80.9%	82.2%	81.6%	84.4%	85.5%	86.9%	85.0%	85.0%
R4	RTT Waiting Times - Non Admitted	RM	CC	95% or above	NTDA	Red /ER = <95%	93.9%	93.4%	93.5%	93.9%	94.3%	94.4%	95.0%	94.9%	95.6%	94.6%	94.9%	95.2%	96.0%	95.4%	95.4%
R5	RTT - Incomplete 92% in 18 Weeks	RM	CC	92% or above	NTDA	Red /ER = <92%	92.1%	92.0%	92.6%	92.1%	93.9%	93.6%	94.0%	93.2%	94.0%	94.3%	94.8%	95.0%	95.1%	95.2%	95.2%
R6	RTT 52 Weeks+ Wait (Incompletes)	RM	CC	0	NTDA	Red /ER = >0	0	1	0	0	0	0	0	15	1	3	3	2	0	0	0
R7	6 Week - Diagnostic Test Waiting Times	RM	SK	1% or below	NTDA	Red /ER = >1%	1.9%	5.3%	1.9%	1.9%	0.8%	0.9%	0.8%	0.7%	1.0%	1.0%	0.7%	1.8%	2.2%	5.0%	5.0%
R8	Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.8%	95.3%	95.9%	95.3%	88.5%	94.7%	93.5%	92.2%	92.0%	90.6%	92.0%	92.5%	93.0%		92.1%
R9	Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	RM	MM	93% or above	NTDA	Red = <93% ER = Red for 2 consecutive mths	94.0%	96.8%	93.4%	94.3%	80.0%	95.0%	98.9%	94.9%	94.4%	95.2%	98.6%	100.0%	93.0%		94.7%
R10	31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	RM	MM	96% or above	NTDA	Red = <96% ER = Red for 2 consecutive mths	98.1%	97.2%	98.5%	98.2%	97.2%	92.9%	93.6%	94.4%	97.9%	91.9%	95.9%	92.5%	95.2%		94.6%
R11	31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	RM	MM	98% or above	NTDA	Red = <98% ER = Red for 2 consecutive mths	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	97.1%	100.0%	96.7%		99.2%
R12	31-Day Wait For Second Or Subsequent Treatment: Surgery	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	96.0%	94.8%	96.4%	98.6%	95.2%	97.0%	90.8%	90.1%	87.8%	94.0%	81.9%	82.4%	80.3%		88.7%
R13	31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	RM	MM	94% or above	NTDA	Red = <94% ER = Red for 2 consecutive mths	98.2%	94.8%	96.3%	99.1%	97.3%	95.6%	93.9%	97.3%	99.0%	96.5%	96.0%	94.7%	95.5%		96.2%
R14	62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	RM	MM	85% or above	NTDA	Red = <85% ER = Red in mth or YTD	86.7%	89.1%	89.1%	92.4%	92.7%	88.5%	73.1%	85.6%	78.8%	75.5%	80.4%	77.0%	84.8%		81.6%
R15	62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	RM	MM	90% or above	NTDA	Red = <90% ER = Red for 2 consecutive mths	95.6%	97.1%	95.1%	91.7%	91.1%	67.4%	73.9%	73.0%	100.0%	87.5%	75.0%	94.4%	93.8%		84.2%
R16	Urgent Operations Cancelled Twice	RM	PW	0	NTDA	Red = >0 ER = >0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R17	Cancelled patients not offered a date within 28 days of the cancellations UHL	RM	PW	0	NTDA	Red = >2 ER = >0	85	9	2	8	10	3	1	1	1	2	2	1	3	4	28
R18	Cancelled patients not offered a date within 28 days of the cancellations ALLIANCE	RM	PW	0	NTDA	Red = >2 ER = >0	New Indicator for 14/15				0	0	0	0	6	0	0	1	1	2	10
R19	% Operations cancelled for non-clinical reasons on or after the day of admission UHL	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.6%	2.1%	1.5%	1.1%	0.8%	1.1%	0.7%	0.6%	0.8%	0.8%	1.2%	1.1%	0.8%	0.9%
R20	% Operations cancelled for non-clinical reasons on or after the day of admission ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	1.6%	1.6%	2.1%	1.5%	0.6%	0.6%	0.3%	2.7%	0.0%	0.9%	1.0%	0.0%	0.8%	1.4%	0.8%
R21	% Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	0.8% or below	Contract	Red = >0.9% ER = >0.8%	New Indicator for 14/15				1.1%	0.8%	1.0%	0.9%	0.6%	0.8%	0.8%	1.1%	1.1%	0.8%	0.9%
R22	No of Operations cancelled for non-clinical reasons on or after the day of admission UHL + ALLIANCE	RM	PW	N/A	UHL	tbc	1739	152	178	139	106	77	98	94	55	90	94	108	102	74	898
R23	Delayed transfers of care	RM	PW	3.5% or below	NTDA	Red = >3.5% ER = Red for 3 consecutive mths	4.1%	4.6%	4.3%	3.8%	4.4%	4.2%	4.0%	3.9%	3.9%	4.5%	4.6%	5.2%	3.9%	3.2%	4.2%
R24	Choose and Book Slot Unavailability	RM	CC	4% or below	Contract	Red = >4% ER = Red for 3 consecutive mths	13%	10%	16%	19%	22%	25%	26%	25%	26%	25%	20%	17%	16%	12%	21%
R25	Ambulance Handover >60 Mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	868	52	207	111	173	253	88	71	50	106	253	343	460	353	2,150
R26	Ambulance Handover >30 Mins and <60 mins (CAD)	RM	CF	0	Contract	Red = >0 ER = Red for 3 consecutive mths	7,075	573	818	601	720	951	671	591	805	736	1,147	1,364	1,170	1,167	9,322

Research

KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-10	Nov-10	Dec-10	Jan-11	YTD
RS1	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	KH	DR	England 650,000 East Midlands 50,000	NIHR CRN	Red / ER = <90%	92%	93%	94%	93%	91%	91%
RS2a	A: Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period.	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	67%	64%	68%	54%	56%	56%
RS2b	B: Proportion of non-commercial studies achieving their recruitment target during their planned recruitment period	KH	DR	England 80% East Midlands 80%	NIHR CRN	Red / ER = <60%	81.0%	81.0%	73%	77%	77%	77%
RS3a	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	KH	DR	600	NIHR CRN	tbc						
RS3b	B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II-IV studies	KH	DR	75%	NIHR CRN	Red <75%						
RS4	Proportion of eligible studies obtaining all NHS Permissions within 30 calendar days (from receipt of a valid complete application by NIHR CRN)	KH	DR	80%	NIHR CRN	Red <80%	90.0%	89.0%	84.0%	82.0%	83.0%	82.0%
RS5a	A: Proportion of commercial contract studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application or First Network Site Initiation Visit	KH	DR	80%	NIHR CRN	Red <80%						
RS5b	B: Proportion of non-commercial studies achieving first participant recruited within 70 calendar days of NHS services receiving a valid research application	KH	DR	80%	NIHR CRN	Red <80%						
RS6a	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 99% East Midlands 99%	NIHR CRN	Red <99%	81.0%	81.0%	81.0%	88.0%	88.0%	88.0%
RS6b	B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	KH	DR	England 70% East Midlands 70%	NIHR CRN	Red <70%	56.0%	56.0%	56.0%	56.0%	56.0%	56.0%
RS6c	B: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	KH	DR	England 25% East Midlands 25%	NIHR CRN	Red <25%	45.0%	45.0%	51.0%	63.0%	54.0%	54.0%
RS7	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	KH	DR	England 13500 East Midlands 510	NIHR CRN	Red <510 Q4	325	438	448	532	624	624
RS8	Deliver robust financial management using appropriate tools - % of financial returns completed on time	KH	DR	England 100% East Midlands 100%	NIHR CRN	Red <100%	100% *Q2	100.0%				100% *Q2

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	KPI Ref	Indicators	Board Director	Lead Director/Officer	14/15 Target	Target Set by	Red RAG/ Exception Report Threshold (ER)	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	YTD
Estates and Facilities	E&F1	Percentage of statutory inspection and testing completed in the Contract Month measured against the PPM schedule.	AC	GL	100%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F2	Percentage of non-statutory PPM completed in the Contract Month measured against the PPM schedule	AC	GL	100%	Contract KPI	Red = ≤ 80%	91.5%	81.2%	95.6%	80.5%	86.6%	87.1%
	E&F3	Percentage of Estates Urgent requests achieving rectification time	AC	LT	95%	Contract KPI	Red = ≤ 75%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F4	Percentage of scheduled Portering tasks completed in the Contract Month	AC	LT	99%	Contract KPI	Red = ≤ 98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E&F5	Number of Emergency Portering requests achieving response time	AC	LT	100%	Contract KPI	Red = >2	0	0	0	0	0	0
	E&F6	Number of Urgent Portering requests achieving response time	AC	LT	95%	Contract KPI	Red = ≤ 95%	95.1%	96.2%	97.3%	97.2%	97.2%	96.6%
	E&F7	Percentage of Cleaning audits in clinical areas achieving NCS audit scores for cleaning above 90%	AC	LT	100%	Contract KPI	Red = ≤ 98%	100.0%	99.1%	100.0%	100.0%	100.0%	99.8%
	E&F8	Percentage of Cleaning Rapid Response requests achieving rectification time	AC	LT	92%	Contract KPI	Red = ≤ 80%	99.6%	89.9%	93.3%	90.5%	91.1%	92.9%
	E&F9	Percentage of meals delivered to wards in time for the designated meal service as per agreed schedules	AC	LT	97%	Contract KPI	Red = ≤ 95%	99.4%	99.5%	100.0%	100.0%	98.9%	99.6%
	E&F10	Overall percentage score for monthly patients satisfaction survey for catering service	AC	LT	85%	Contract KPI	Red = ≤ 75%	96.7%	97.3%	97.3%	96.7%	93.8%	96.4%

S1b – CDIFF local target

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly)	Latest month performance	YTD performance	Forecast performance for next reporting period
The cases of CDT have been the subject of Root Cause Analysis and there are no discernible factors that link these cases to date.	Action plans that have resulted from the RCA should be presented to the CMG Infection Prevention Groups and should follow the RCA process flow chart as described in the Infection Prevention Toolkit In line with the 'updated guidance in the diagnosis and reporting of Clostridium difficile' the cases have been sent to Commissioning Group that has been established to review each case individually. The comments from this group will be received within seven working days. This process commenced in October and sample positive cases that are the subject of RCA will be sent monthly for review. A thematic review of CDT cases will be undertaken with the results presented to the March EQB and CQRG meetings now and not February in line with request from commissioners	4	7	61	N/A

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Traj 14/15	7	8	5	7	6	7	7	7	6	7	7	7	81
Internal Traj 14/15	4	5	4	5	4	4	4	4	4	4	4	4	50
Actual Infections 14/15	4	6	5	7	2	5	7	7	11	7			61

Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Elizabeth Collins - Lead Nurse Infection Prevention & Control

S3 Never events

<table>
<tr><th colspan="2"></th><th>Target</th><th>Jan 14</th><th>YTD</th><th>Forecast</th></tr>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><td>NIL</td><td>1</td><td>3</td><td>3</td></tr>
<tr>
<td>A patient was listed for surgery at Melton Hospital by a Podiatric Surgeon to straighten the 3rd toe on her right foot.

On the morning of surgery (22 December 2014) the Podiatry Assistant confirmed with the patient the site and documented consent. She marked the patient's foot on the top with an arrow pointing towards the 3rd toe.

Whilst the latter was taking place the Podiatric Surgeon reviewed the MRI images for the patient and considered that the 2nd toe on the right foot required surgery.

The patient was brought into the theatre and the WHO checklist completed whilst the Surgeon was scrubbing up. He was not fully engaged in the check and the Podiatry Assistant was not present in Theatre to participate in the checks. Surgery was undertaken on the 2nd toe.</td>
<td>1. Change in practice: marking extending to digit implemented immediately.
2. Messages regarding WHO checklist reinforced at meeting on 6 January 2015 with teams involved.
3. Podiatry Assistant must be present in theatre when WHO checklist completed.</td>
<td colspan="4">2013/14 Performance by Quarter
<table><tr><th>13/14 Q1</th><th>13/14 Q2</th><th>13/14 Q3</th><th>13/14 Q4</th></tr><tr><td>0</td><td>0</td><td>1</td><td>2</td></tr></table>
Three Never Events will trigger UHL as 'red' on this indicator for 2014/15.

<table><tr><td>Expected date to meet standard</td><td>N/A</td></tr><tr><td>Revised date to meet standard</td><td>-</td></tr><tr><td>Lead Director</td><td>Moira Durbridge, Director of Safety and Risk</td></tr></table></td>
</tr>
</table>

Commentary:

1. The definition of a Never Event is: "Serious, largely preventable PSIs that should not occur if the available preventative measures have been implemented by healthcare providers".

2. In relation to UHL performance:

   - In 2012/13, UHL reported 6 Never Events
   - In 2013/14, UHL reported 3 Never Events
   - For Quarters 1 and 2 in 2014/15, there were no Never Events reports and good compliance with the regulatory framework was demonstrated. However, in Quarter 3, 2014/15, 2 Never Event was reported and in Quarter 4, 1 Never event has been reported to date.

3. Case One Never Event occurred because the surgeon made an assumption rather than undertaking a definitive check.

4. Case Two Never Event occurred because of non-compliance in respect of certain elements of the Safer Surgery Policy.

S17 – Maternal Deaths

INDICATOR:

Reason for Breach/Exception Report	Actions that have been taken or are planned to prevent recurrent, where applicable	Target	Latest performance	YTD performance	Forecast performance for next reporting period
A lady was admitted to ED late January via ambulance with sudden onset of right sided weakness, vomiting and increasing blood pressure. A diagnosis of a catastrophic left hypertensive bleed with compression of the ventricles was made. Following discussion with QMC, surgery was ruled out. The lady deteriorated and died on ITU the next day. On admission to ED there was a suspicion that she may be pregnant – a scan later confirmed a pregnancy of approximately 19 weeks. The lady's husband was unaware that she was pregnant.	This unexpected maternal death was reported to the Coroner, but an inquest is not required. The CCG and NHS England were informed. Confirmation was received that the patient had not been seen by her GP in over 6 months. As per CCG guidance this had to be escalated as a maternal death. A decision was made by the CCG that an RCA investigation was not required as there were no omissions or mismanagement in care that led to the indirect maternal death.	**0**	**1**	**1**	**0**

Deliveries and Maternal Deaths per Financial Year

Financial Year	Deliveries	Maternal Deaths
2012/13	10,694	1
2013/14	10,230	3
2014/15 YTD (16/2/15)	9,347	1

Expected date to meet standard / target	N/A
Lead Director / Lead Officer	Ian Scudamore, Clinical Director Elaine Broughton, Head of Midwifery

C7 - Complaints Re-opened

	Target	Jan 15	Forecast
What is causing underperformance? / What actions have been taken to improve performance?	<9%	17%	

157 Formal complaints were received in January 2015 and **26 (17%)** were re-opened. The thresholds for an exception are >10% of complaints re-opened 3 months in a row or any month over 15%.

In January 7 of the complaints which re-opened were first received prior to October 2014. The following table outlines when the remaining were first received.

First Received	No. Re-opened
October '14	3
November '14	7
December '14	8
Jan '15	1

For the same period last year 16% were re-opened which does reflect a seasonal trend with fewer re-opening in December.

5 of the re-opened complaints had been previously re-opened and required either a further response or a local resolution meeting therefore a review of the processes will take place to consider only re-opening complaints once whilst trying to achieve local resolution.

The following table shows the number of re-opened complaints in Jan '15 by CMG.

	Received	Re-opened	% Reopened
CHUGGS	23	3	13%
RRC	15	2	13%
ESM	42	9	21%
ITAPS	5	1	20%
MSS	32	7	22%
CSI	10	1	10%
W&C	20	1	5%
The Alliance	3	0	0%
Corporate	7	1	14%
Totals:	**157**	**25**	**16%**

1) Greater scrutiny of the complaint and response prior to re-opening to establish if anything further can be contributed. Also if new concerns are raised then a new complaint to be logged instead of re-opening the original concerns

2) Complaints only to be re-opened once whilst trying to achieve local resolution even where 2 responses and a local resolution meeting are required.

3) Those CMGs with a high number of complaints re-opening to review the final responses and consider if these were fit for purpose.

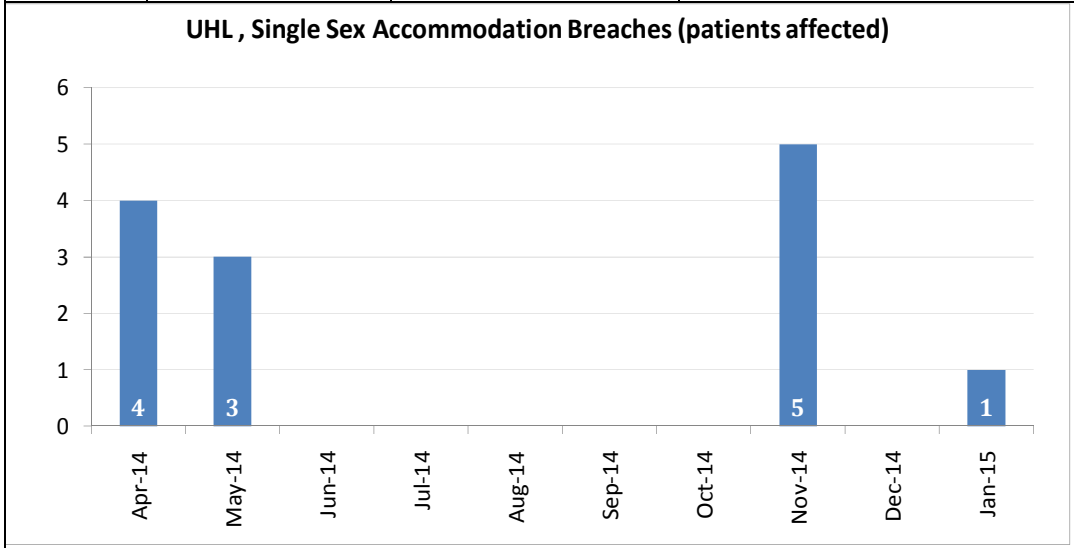
Previous Months performance

	Oct 14	Nov 14	Dec 14	Jan 15
No. of Formal Complaints Received	197	162	147	157
No. of Complaints Re-opened	23	17	14	26
% re-opening	12%	10%	10%	17%

Expected date to meet standard	March 2015
Revised date to meet standard	
Lead Director	Moira Durbridge, Director of Safety and Risk

C8 - Single sex accommodation breaches

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
During January 2015 the Same-Sex policy was not adhered too, effecting one patient on one occasion. This occurred in the HDU bay on ward 26 at the Glenfield Hospital, the causes were: Sudden change in demand for high dependency facilities. Night staff successfully focusing upon the needs of a deteriorating patient and not successfully finding a solution to the resulting same sex accommodation breach. Limited communication regarding bed availability . .	Meetings have been held with Nursing and Duty Management leads, this information has then been cascaded to the clinical staff. A Route Cause Analysis has been completed, addressing learning needs and looking at preventing future breaches.	**0**	**1**	**13**	**0**



Expected date to meet standard / target	Every month
Revised date to meet standard	N/A
Lead Director / Lead Officer	Heather Leatham, Assistant Chief Nurse

W9 Sickness absence

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month	YTD performance	Forecast performance for next reporting period
1. Sickness absence is reported a month in arrears. 2. There has been an increase in sickness absence from July 2014 of 1.39%. 3. Sickness levels for December 2014 are the same as those first reported for December 2013 - 4.7%. 4. Sickness absence reporting highlights an adjustment of around 0.5% due to late closures. It is therefore expected the December 2014 sickness absence rate will be adjusted in the coming months. 5. In the last two years December 2012 to December 2014 we have seen: a. A reduction in staff taking sickness absence (December 2012 – 67.2%, December 2014 – 65.6%) b. An increase in staff taking sickness absence in excess of 28 days (December 2012 – 7.6%, December 2014 – 8.28%) 6. Feedback from Clinical Management Group and Directorates Leads indicates that the increased sickness absence is due to :- a. Increased operational pressures / activity b. Seasonal variations c. Inaccurate data – delays in closing absences d. Management changes / handovers e. Vacancies and other absences reducing management time f. Service pressures delaying sickness absence management	1. Improved data through weekly SMART (Sickness Monitoring and Reporting Team) reports forwarded to lead managers highlighting open absences, closed absences and triggers (3 episodes / more than 10 days / 2 working weeks) 2. Discussion at CMG / Directorate Boards and across services / areas with specific actions confirmed 3. Circulation of breakdown of CMG performance by cost centre covering monthly and cumulative sickness absence. 4. Making it Happen Reviews, to discuss and agree actions for the management and support of open absences, 'triggers' and complex cases with line managers. 5. 6 monthly CMG Sickness Performance Reviews / Case reviews with Occupational Health and Senior and independent HR colleagues. 6. Sickness Absence training continues for line managers, and a new programme has been introduced for those administering the sickness absence paperwork. **Further Actions:** 7. In addition to the corporate sickness absence training, local training is facilitated for CMG's / Directorates in response to specific needs – management of long term absence, documentation etc. 8. Local actions to address high sickness absence include CMG Management Team 'Hot Spot' meetings, Staff Engagement events to reduce sickness absence and improve the management of sickness absence. 9. Improvement plans including timescales are discussed and agreed at CMG / Directorate level to reduce sickness absence and increase performance in the management of sickness absence. 10. Specific staff support and targeted management of stress related absences.	**UHL Stretch target 3% (previous SHA target 3.4%)**	**4.8%**	**3.7% (average)**	**3.50% average (April 2015)**

Trust Performance

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
3.4%	3.3%	3.3%	3.4%	3.4%	3.7%	4.0%	4.0%	4.8%

Expected date to meet standard / target	Monthly Target
Revised date to meet standard	April 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Kalwant Khaira, CMG HR Lead (HR Sickness Absence Lead)

W13 – Statutory and Mandatory Training

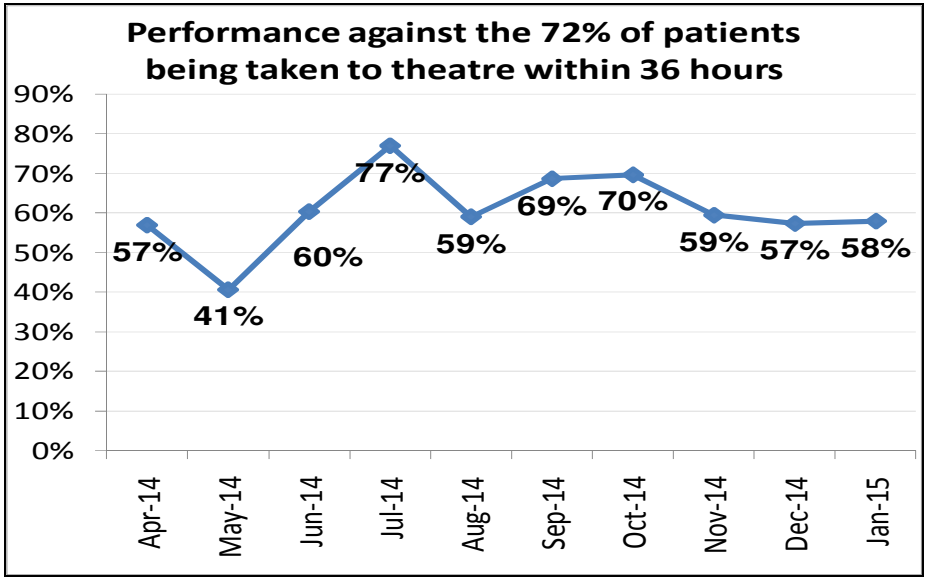
What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
We note that Statutory and mandatory Training is underperforming for the second month in a row. This minimal underperformance (by approx. 1%) results primarily from a reduction in attendance at face to face training sessions and completion of eLearning during December and January 2015 given service demands and pressures. We recognise that attendance at face to face training relies on staff being covered to attend, particularly in clinical areas and therefore generally completion rates for fire, resuscitation and manual handling training are lower than previous months. The underperformance is also partly due to the expiry of certain eLearning courses that were massively subscribed to in January 2014 due to targeted campaign such as Information Governance. Therefore the number of staff that are out of date for this programme in January 2015 are significant.	1,200 team leaders (as recorded on the eUHL System) with access to the 'Team Builder' function have been contacted directly and requested to focus upon key training including Information Governance Training. The Core Training Team has liaised with the Moving & Handling team to improve engagement and clarity regarding attendance and access to their training sessions. All Subject Matter Experts are being contacted to identify and share across the group successful strategies. A new guide to 'Checking your Required Training' will be distributed to all staff during February to improve compliance levels and increase awareness of the targets and the necessity of training completion. Automated Reminder emails will be generated by the eUHL system before courses expire. This has been in development since September and should be up and running before the end of February 2015.	31st March, 2015 – 95%	6th Feb, 2015 – 89%	89%	95% at end of Quarter 4 / Year End

CMG / Corporate Directorates	Fire Training	Moving & Handling	Infection Prevention	Equality & Diversity	InformationGover'ce	Safeguard Children	Conflict Resolution	Safeguard Adults	Health & Safety	Resus - BLS Equivalent	Average
CHUGS	84%	84%	88%	94%	85%	94%	93%	93%	92%	85%	89%
CSI	90%	92%	92%	96%	89%	95%	95%	92%	95%	82%	92%
ESM	87%	86%	85%	92%	83%	93%	91%	91%	89%	84%	88%
ITAPS	88%	94%	89%	96%	87%	96%	95%	95%	93%	88%	92%
MSS	82%	83%	81%	93%	85%	94%	92%	92%	91%	82%	88%
RCC	82%	86%	87%	94%	87%	92%	91%	90%	91%	84%	88%
W&C	83%	82%	79%	92%	85%	95%	91%	88%	88%	84%	87%
The Alliance	94%	90%	92%	93%	92%	94%	91%	92%	93%	42%	87%
Corporate	82%	88%	82%	95%	86%	96%	92%	92%	89%	79%	88%
Total compliance by subject	85%	87%	86%	94%	86%	94%	92%	91%	91%	83%	89%

Expected date to meet standard / target	90% - 31ST, January 2015 95% - 31st March 2015
Lead Director / Lead Officer	Emma Stevens, Acting Director of Human Resources Bina Kotecha, Assistant Director of Learning and OD

E12 – No. of # Neck of femurs operated on 0-35 hrs - Based on Admissions

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
All of the issues set out in previous reports continue in the service and are exacerbated at times of heightened activity. The acceptance of out of area elective and emergency spinal work is having a detrimental effect on the main trauma capacity as spinal patients are medically prioritised over 'other' trauma which has a knock on effect on #NOF capacity. With this additional demand the current theatre capacity for trauma is insufficient and patients have to wait longer than usual whilst short notice additional operating sessions are arranged. Work continues within the spinal network with regards to spinal capacity across the region and how UHL fits into the future plans.	An action plan from the recent preoperative LiA listening event is being written up. The 4 main work streams are: • ED Admissions • Medical Work Up • Theatre Scheduling • Theatre Productivity Project teams are set up to look at each of the work streams in detail and produce their individual action plans for delivery of improvement within the LiA timescales. The LiA sponsor group continue to meet weekly to push actions forward and assess progress. A meeting took place with the CCG to discuss which aspect of the Trauma service should be included in the quality schedule. It was agreed that time to theatre is the most significant and achievement of this would almost guarantee success in the remaining indicators. Realistically this will not be achieved until all of the LiA work is complete and embedded. The date given for achievement was the end of Q3 2015/16	72%	58%	61%	62%



Performance by Quarter

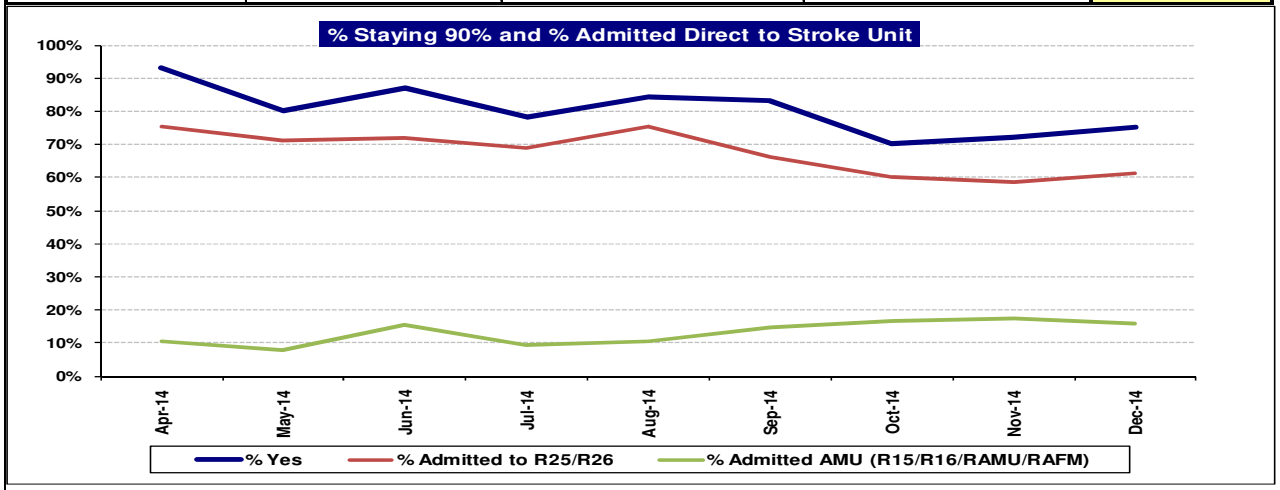
13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
65%	52%	68%	62%	

Expected date to meet standard	December 2014
Revised date to meet standard	December 2015
Lead Director / Lead Officer	Richard Power, MSS CD / Maggie McManus, MSS Deputy Head of Operations

E13 – Stroke - 90% of Stay on a Stroke Unit

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
A recent audit performed by Dr Rachel Marsh has highlighted a number of issues (see full report Appendix 1) Main issues: Lack of stroke beds at times of high in flow in terms of both stroke patients and all admissions Insufficient access to therapy services leading to longer lengths of stay Delays in transfers of care Social care delays Diagnostic confusion at first presentation. Referral delays Clarification of reporting rules and exceptions including surgical wards and ITU.	**Actions taken thus far:** Support from executive leads including the CE to ring fence beds. Daily list of patients awaiting rehabilitation beds emailed to bed bureau and bed managers to support better 'out flow'. Monthly audit of notes to confirm presence of stroke where 90% not achieved Recruitment of fixed term occupational therapist to cover maternity leave Improvement in Trust performance has had an effect on Stroke performance in January early cut. **Actions planned:** Introduce daily record of any non-stroke patients on the stroke unit and reason Monthly audit of coding plus reason for patients not achieving 90% stay Develop a business plan with therapy services to increase physiotherapy and occupational therapists Review of LPT contract to increase Speech and Language therapists Escalate delays in transfers of care. Ensure the stroke bed policy is robustly enforced and re-issue the policy via senior management. Review bed usage across the stroke unit to ensure capacity is maximised. Review exclusion criteria regarding 90% stay including ITU and surgical stays.	**80%**	**75.2%**	**80.0%**	**80.0%**

Month	No	Ave Spell LOS (No)	Yes	Ave Spell LOS (Yes)	Total	Overall Ave LOS	% Yes
Apr-14	6	12.3	79	13.3	85	13.2	92.9%
May-14	15	7.7	61	12.2	76	11.3	80.3%
Jun-14	11	7.2	74	13.6	85	12.7	87.1%
Jul-14	21	12.3	75	14.9	96	14.3	78.1%
Aug-14	15	6.9	82	15.2	97	13.9	84.5%
Sep-14	17	12.0	84	15.3	101	14.8	83.2%
Oct-14	32	11.6	76	10.1	108	10.5	70.4%
Nov-14	29	9.9	75	15.7	104	14.0	72.1%
Dec-14	25	17.2	76	15.6	101	16.0	75.2%
2014/15	**171**	**11.1**	**682**	**14.1**	**853**	**13.4**	**80.0%**

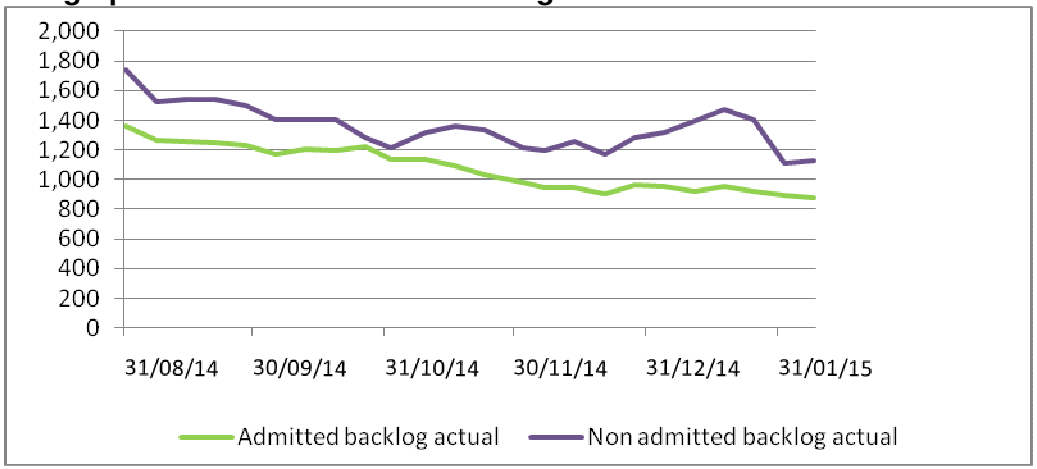


Expected date to meet standard / target	January 2015.
Lead Director / Lead Officer	Dr Ian Lawrence, Clinical Director for ESM / Dr Rachel Marsh, Head of Stroke Services

R3 – RTT Waiting Time - Admitted

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest performance	YTD performance	Forecast performance for next reporting period
The admitted backlog is too high to deliver sustained performance of the admitted target. Reduction in the size of the backlog has been significant but the progress in the next 2 months has to be accelerated in key specialties. **By key speciality:** -Ophthalmology, continues to perform well. • General surgery, backlog continues to reduce as planned. • Urology the backlog has not reduced and is a significant cause of concern. • Max fax backlog has reduced but the paediatric element has been hampered by lack of paediatric elective capacity as have both paediatric surgery and urology • Gynaecology, has seen a steady reduction in the backlog this needs to accelerate in March. • Orthopaedics, backlog has remained static. It is a significant risk due to the unstainable non admitted backlog position	The Trust is achieving 2 of the 3 RTT standards: Non admitted performance is 95.4% against a target of 95%. Incomplete performance 95.2% against a target of 92%. The revised weekly access meeting is working well as is the predictive ability of ensuring delivery. The TDA has requested a reduction in the total backlog of 370 patients. The Trust is on track to deliver this through: • Additional activity at weekends until the end of March • Urology additional in house and independent sector activity has started. • Additional weekend work across the paediatric specialities has also started • Additional work in house but also with the local independent sector. Over 500 patients sent to the IS. There are also 75 patients sent from Orthopaedics • Orthopaedics remains the greatest risk to the Trust RTT performance. Weekend working continues, additional outsourcing to the local Independent sector for elective activity has also started.	90% treated within 18 weeks	85% (UHL and Alliance)	85%	86%

The graph below illustrates the backlog reduction at Trust level



Risks

Orthopaedics and Urology remain the biggest risks to the Trust overall performance. The TDA agreed backlog by the end of Febraury is no more than 814. As at the end of January this stood at 915. Agreement has been reached with both the TDA and commissioners that backlog reduction should continue with the clear aim of admitted achievement during April 2015.

Mitigation

All key speciality plans being reviewed by Director of Performance and Information.
Urology on weekly meetings.
Orthoapedics on daily reproting of key improvement metric.
Re modelling of anticipated performance.
Ongoing additional activity in key specialities.
Additional outsourcing of activity in January to March, supported by TDA additional funding.
Weekly CCG RTT meetings.

Expected date to meet standard / target	April 2015
Lead Director / Lead Officer	W Monaghan, Director of Performance and Information C Carr, Head of Performance

R7 – Diagnostic Waiting Times

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Standard</th><th>January 2015</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">The Trust is measured on the waiting times of the top 15 diagnostic modalities, these are reported at the end of each month. These modalities cross all CMGs

Factors that have caused this under performance are:

Imaging (accounting for 74% of breaches)
- Cardiac CT and MRI, there remains insufficient capacity – this is ongoing issue and these are supervised scans so need consultant radiologist availability.
- MSK MRI , these are consultant specific test
- Utrasound. Agency dependent solution due to national shortage stopped for two weeks within December due to Christmas – This provided a special cause within January.

Dexa (accounting for 18%of breaches)
- During November there was a system failure resulting in the breaching of the standard. No alternative capacity available.

Endoscopy (accounting for 19% of breaches)
- Colonoscopy / Flexi sigmoidoscopy / Gastroscopy

Sleep studies (16 breaches)
- Capacity issues with Paediatric provision.

Additionally, there were small volumes of breaches of the standard in a number of other modalities.

Collectively these have caused a breach of the standard a total of 431 patients waiting over 6 weeks.</td><td rowspan="5">Weekly diagnostic PTL meeting established to review future performance cross CMG and develop shared learning of a multi CMG provision.

Control totals established to help focus delivery with additional capacity where there is risk of breaching encouraged, in addition to dating patients in date order

February performance on track for 1% deliver currently, with further validation to follow.

Trajectory is for future months to deliver nearer to 0.8% performance.

Cardiac CT and MRI
Additional sessions being carried out by cardiologists during December to February. Radiographer led scanning to be implemented February (CT) and April (MR).
InHealth mobile unit on-site 13 days February/March

MSK imaging capacity
New MSK radiologist has started, with locum continuing to help manage backlog.

Dexa
Scanner now repaired. Contingency plan between Imaging and Rheumatology implemented.
Recovery plan implemented within January, benefits to be seen within February return. Currently tracking <0.8% delivery for next submission.

Endoscopy
Additional endoscopy work is being carried out by Medinet on UHL site from mid January. Recovery plan implemented within January, benefits to be seen within February return. Currently tracking <0.8% delivery for next submission.

All other modalities
Pro-active PTL management, additional capacity.</td><td><1% over 6 weeks</td><td>UHL and Alliance combined 5.0%</td><td>5.0%</td><td>1%</td></tr>
<tr><td colspan="4">Risks:

There remain risks to achievement of this standard due to the instability of a number of diagnostic modalities which collectively make up this standard although increased visibility and forward planning within nascent PTL meetings will mitigate against this.

Capacity pressures within MR and paediatric sleep studies/endoscopy remain a challenge.</td></tr>
<tr><td colspan="2">Expected date to meet standard / target</td><td colspan="2">November 2014</td></tr>
<tr><td colspan="2">Revised date to meet standard</td><td colspan="2">February 2015</td></tr>
<tr><td colspan="2">Lead Director / Lead Officer</td><td colspan="2">Will Monaghan, Director of Performance and Information
Suzanne Khalid, CSI CMG Director
Matthew Archer, CSI Head of Operations</td></tr>
</table>

R8-15 Cancer Waiting Times Performance

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance December	Performance to date 2014/15	Forecast performance for January
R8 There has been an annualised increase of 18% in 2WW suspected cancer referrals in 2014/15 to date This is likely to continue to grow This has not been matched by increased provision of carved out availability, nor sufficient response to individual cancer type awareness campaigns **R10, 12, 14, 15** The system for the integration of complex cancer pathways remains in place (**R14, R15**) Access to cancer diagnostics remains good. The delivery of timely treatments (**R10, R12**) lies within the gift of services for surgery, and the oncology department for chemotherapy and radiotherapy. Chemotherapy and radiotherapy treatments have remained timely for the most part. The issue is adequate access to surgical capacity. There is no shortage of overall surgical capacity, the poor performance results from the failure to appropriately prioritise cancer pathways in the face of competing priorities.	The Cancer Centre has taken the following actions to further strengthen the support offered to the CMGs in delivering cancer performance; All 2WW referrals processed within 24 hours of receipt since December 2014 Revision to Monday CAB meetings to ensure that patient level management may be expedited whilst reducing the time commitment of the meeting Cancer tracking reaching earlier into pathways to flag delays to services empowered to expedite "next steps" maximising opportunities for host services to deliver treatment dates within breach. These corporate actions are facilitating. Delivery of cancer performance will continue to depend upon CMGs prioritising cancer patient pathways in recognition of their complexity and the tight time lines compared with other elective care standards. The Cancer Centre and Director of Performance will meet with the CMGs to review how best they can be supported in the delivery of these standards. Business Case for the administrative staff required to deliver the enhanced support to services for their cancer pathways taken to Revenue Investment Committee on 13.02.2015	**R8 2WW 93%**	93%	92.1%	92.3%
		R10 31 day 1st 96%	95.2%	94.6%	88.9%
		R12 31 day sub (Surgery) 94%	80.3%	88.7%	86.7%
		R14 62 day RTT 85%	84.8%	81.6%	75.4%
		R15 62 screening 90%	93.8%	84.2%	81.3%

Performance by Quarter

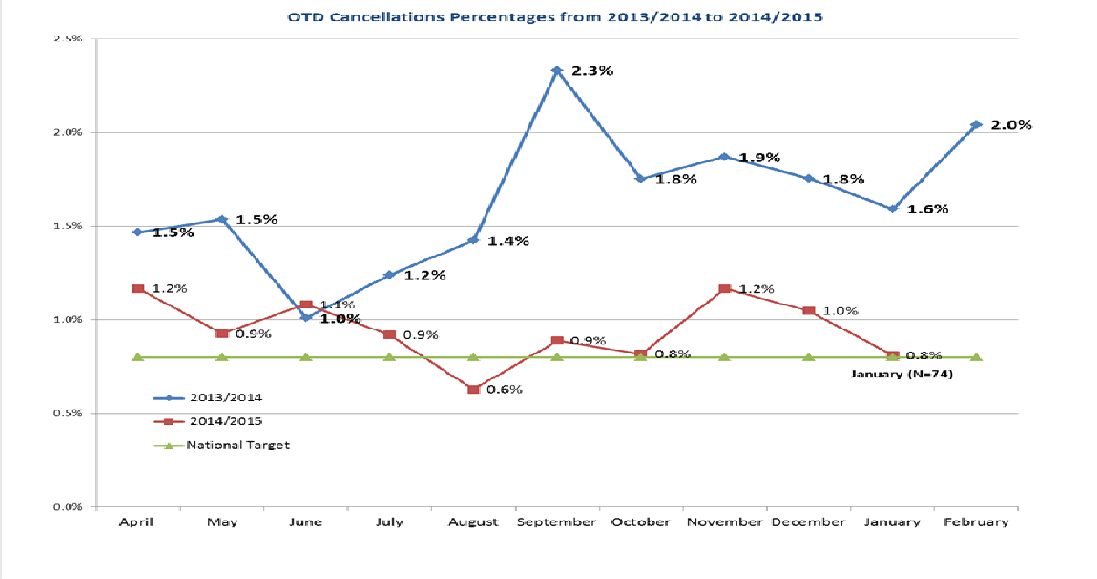
	13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
R8	94.8%	92.2%	91.6%	92.5%	
R10	98.1%	94.6%	94.6%	94.6%	
R12	96.0%	94.2%	90.5%	81.5%	
R14	86.7%	84.1%	79.9%	80.8%	
R15	95.6%	78%	85%	89.2%	

Expected date to meet standard / target	R8 – Recovered December R10,12 – Recovery expected M12 2014/15 R14,15 – Recovery expected M6 2015/16
Revised date to meet standard	Subject to modelling – details in next report
Lead Director / Lead Officer	Will Monaghan, Director of Performance and Information Matt Metcalfe, Consultant Hepatobiliary and Pancreatic Surgeon

R16-R22 - cancelled operations

INDICATOR: The cancelled operations target comprises of three components:
1. The % of cancelled operations for non-clinical reasons On The Day(OTD) of admission
2.The number of patients cancelled who are offered another date within 28 days of the cancellation
3. The number of urgent operations cancelled for a second time.

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly) 1)On day=0.8% 2) 28 day = 0 3)urgent second time=0	Latest month performance – Jan 15	YTD performance (inc Alliance)	Forecast performance for next reporting period
This month UHL is compliant with the 0.8% target. This target has not been achieved in winter since 2010. Last year January UHL had 151 cancellations (1.6%). There were 78 fewer cancellations this January. The OTD cancellation reasons remain similar to last month. 21 out of 74 were patients cancelled due to HDU/ITU bed unavailability. Emergency admissions to the LRI critical care unit increased significantly this year compared to the last three years adding pressures to OTD cancellations and 28 days breaches in January. There were four, 28 day breaches due to ITU/HDU pressures or complex procedures requiring specific medical input.	A number of work streams have started aimed at reducing OTD cancellations including a LIA project. A successful LIA event was completed with participation of 48 staff in all three sites. Lots of useful feedback and a number of new ideas were provided by the staff to reduce cancellations. The LIA team are working to implement the changes suggested. <u>Risks to delivery of recovery plan</u> HDU and ITU bed availability due emergency pressures are still a high significant risk to OTD cancellations and 28 day breaches. The situation has been monitored on a daily basis to try to prevent OTD cancellations. Plans are in discussion to improve the patient booking processes and maintain a realistic number of bookings who will require critical care post operatively.	1) 0.8% 2) 0 3) 0	1) 0.8 % 2) 6 3) 0	1) 0.9% 2) 39 3) 0	1) 0.9% 2) 3 3) 0



Expected date to meet standard / target	March - On the day March – 28 day
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer Phil Walmsley, ITAPs Head of Operations

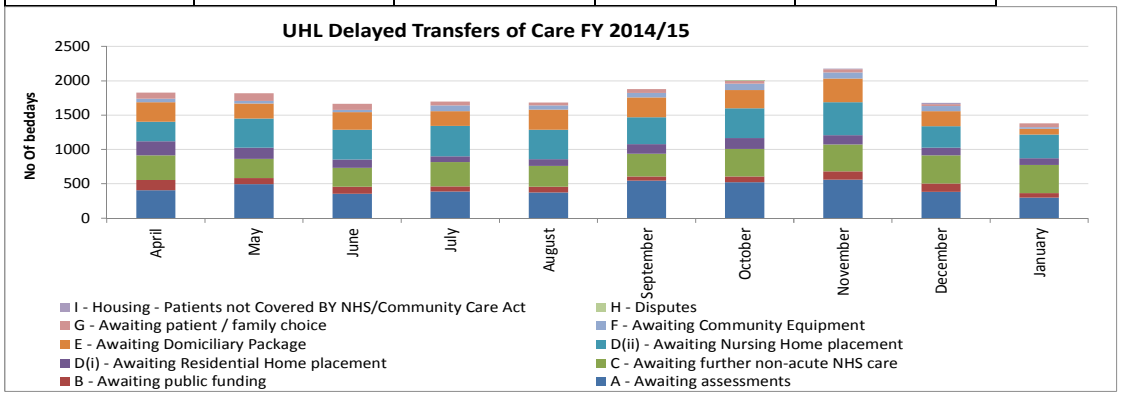
R23 Delayed Transfers of Care

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There has been an decrease in delays due to DTOC in December and January. There remains concern about the availability of packages of care in the County Local Authority. Interim placements in care homes are offered to patients but are not always accepted. There continue to be a number of DTOCs due to slow discharges to care homes. A large number of patients remain delayed whilst waiting for community hospital beds. There are robust mechanisms for transferring patients as soon as possible, but mixed sex and location issues remain issues that delay discharge	The ICRS and ICS teams continue to attend wards to identify patients that they could take directly in to their home based services. This has been particularly successful with the City services and lessons learnt are being discusses with county colleagues There is on-going emphasis regarding therapists reducing the required package of care to try to ensure faster discharge which appear to have had some success. Local Authority staff have been asked to ensure that patients are not offered choice about accepting an interim placement, which appears to have had some success in discharging patients. Ward Two at the LGH has been closed. Good working around discharging directly from wards rather than transferring patients to Ward 2 who were know DTOCS has been instrumental in closing this facility.	3.5%	3.2%	4.2%	4.5%

Row Labels	A - Awaiting assessments	B - Awaiting public funding	C - Awaiting further non-acute NHS care	D(i) - Awaiting Residential Home placement	D(ii) - Awaiting Nursing Home placement	E - Awaiting Domiciliary Package	F - Awaiting Community Equipment	G - Awaiting patient / family choice	H - Disputes	I - Housing - Patients not Covered BY NHS/Community Care Act	Grand Total
April	407	148	356	207	285	285	55	87			1830
May	494	90	277	166	425	218	34	113			1817
June	353	103	277	122	433	253	36	89			1666
July	387	77	353	82	444	215	85	54			1697
August	371	87	302	98	430	294	61	41			1684
September	546	57	333	141	394	286	65	57			1879
October	520	84	402	159	434	266	95	40	4	3	2007
November	561	119	392	134	484	343	88	46		9	2176
December	384	120	408	113	312	222	74	26		21	1680
January	298	65	410	98	345	87	22	53			1378

Performance by Quarter

13/14 FYE	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
4.1%	4.2%	4.1%	4.6%	



Expected date to meet standard / target	TBA
Revised date to meet standard	TBA
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

R24 Choose and Book

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="4">The Trust is measured on the % of Appointment Slot Unavailability (ASI) per month.

The Trust has not met the required the <4% standard for circa 2 years and where it has met this standard it has been unable to maintain it for consecutive months.

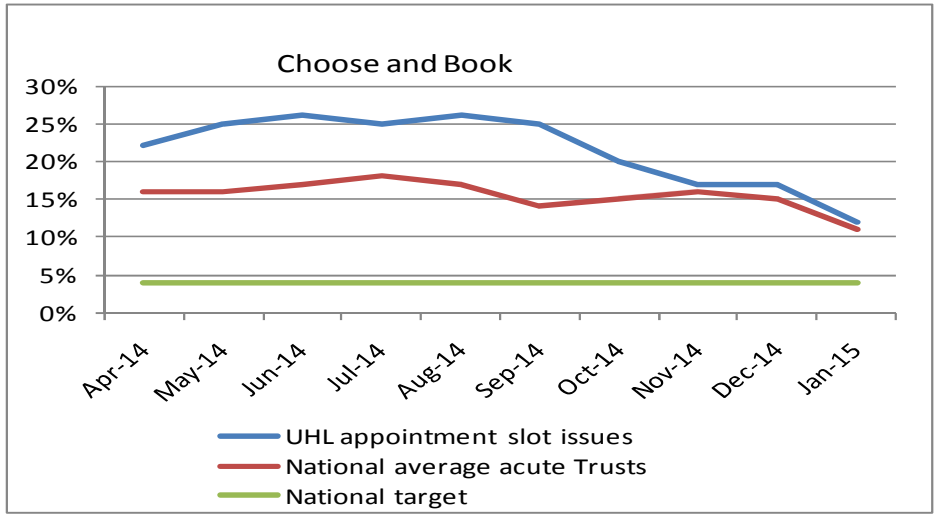
The two most significant factors causing underperformance are:

• Shortage of capacity in outpatients
• Inadequate recurrent training and education of administrative staff in the set up and use of the choose and book process

The issues are notably: General Surgery and orthopaedics and Urology.</td><td rowspan="4">Capacity

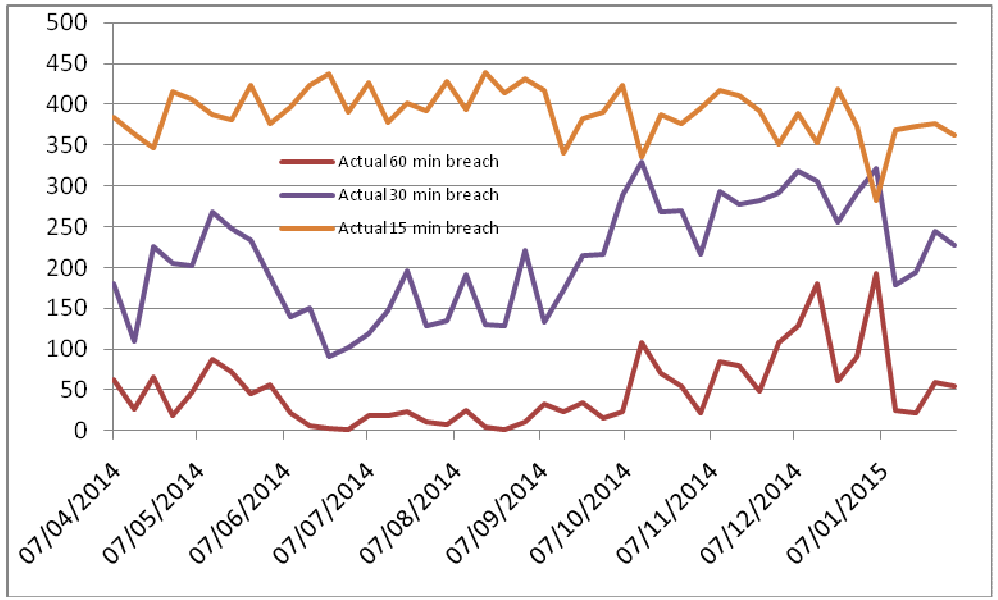
Additional capacity in key specialties is part of the RTT recovery plans.

Training and education

The comprehensive training and education of relevant staff in key specialties continues, to ensure that choose and book is correctly set up and that supporting administrative purposes are fit for purpose.
A speciality level ‘score card’ to highlight areas required for improvement is being distributed weekly to CMGs. This highlights areas for concern and actions required.</td><td><4%</td><td>12%</td><td>21%</td><td>15%</td></tr>
<tr><td colspan="4"> 
</td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="3">January 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="3">March 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="3">Will Monaghan, Director of Performance and Information
Charlie Carr, Head of Performance</td></tr>
</table>

R25 and R26 Ambulance handover > 30 minutes and >60 minutes

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
Difficulties in accessing medical beds continue to lead to a backlog in the assessment area of ED. This delays movement out of the assessment area and delays handover. January's performance improved due to consistently having beds in AMU so improving flow out of the ED. It should be noted that the overall attendances in January via ambulance have gone down by 27 compared to December	A further meeting took place with EMAS in January. There are a series of actions that are being progressed to manage delays in handover. Key ones include visibility of patients on 'the stack' for ED to highlight a likely problem. This allows ED to try an pre-empt delays in handover. To review clinical in put in to 111 calls to try to avoid unnecessary attendances Clarification on communication process for when there is build-up of delays in ED	0 delays over 30 minutes	> 60 min 6% 30-60 min – 24% 15-30 min – 33%	> 60 min 3% 30-60 min – 17% 15-30 min – 36%	



Expected date to meet standard / target	
Revised date to meet standard	
Lead Director / Lead Officer	Richard Mitchell, Chief Operating Officer, Phil Walmsley, ITAPS Head of Operations

RS2A Proportion of commercial contract studies achieving their recruitment target during their planned recruitment period

<table>
<tr><th>What is causing underperformance?</th><th>What actions have been taken to improve performance?</th><th>Target (mthly / end of year)</th><th>Latest month performance</th><th>YTD performance</th><th>Forecast performance for next reporting period</th></tr>
<tr><td rowspan="5">East Midlands is currently 6th of the 15 LCRNs for this metric with no LCRN currently achieving the 80% target, highest is currently 65%

A lot of variables impact on recruitment achieved, after the recruitment target is set, for example:

● Impact of global performance and earlier end dates giving less time to recruit
● Changes in UK practice during set up/ recruitment
● Protocol changes prior to initiation
● Understanding of targets and alignment on the source of the target sites are measured on</td><td rowspan="5">1. Migration of the performance data for all open and closed commercial research onto one internet based system to track performance for 2014/15.

2. Implementation of a provisional performance management process involving the Industry Team and Delivery Managers to escalate studies not recruiting to target within 24 hours and to align targets.

3. Meetings with key research teams to discuss the importance of target setting and aligning the approach across the region so the target is reflective of the contract figure.

4. 6 to 8 weekly performance meetings with delivery managers have been introduced to address this issue from the start of December.

5. Collation of local information to report on the actual figure to take account for the lag in National reporting.</td><td>80%</td><td>56%</td><td>56%</td><td>56%</td></tr>
<tr><td colspan="4" rowspan="4"></td></tr>
<tr><td>Expected date to meet standard / target</td><td colspan="2">April 2015</td></tr>
<tr><td>Revised date to meet standard</td><td colspan="2">May 2015</td></tr>
<tr><td>Lead Director / Lead Officer</td><td colspan="2">Daniel Kumar, Industry Delivery Manager, CRN: East Midlands</td></tr>
</table>

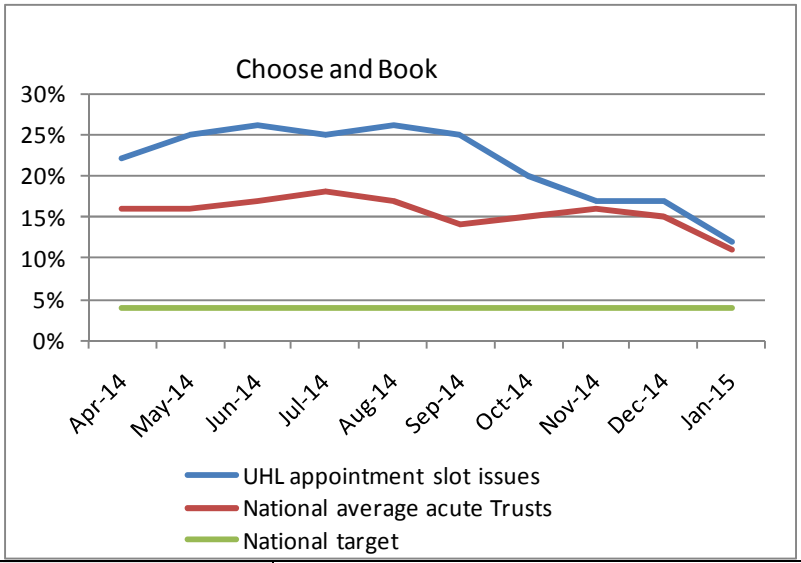
RS6A : Proportion of NHS Trusts recruiting each year into non-commercial NIHR CRN Portfolio studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
The NIHR Clinical Research Network has an HLO with the Department of Health for 99% of Trusts in England to recruit to CRN Portfolio research each year. This has been passed down to local research networks. There are 16 Trusts within the East Midlands region, with 14 Trusts currently reporting recruitment. The two who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Lincolnshire Community Health Services (LCHS)	1. **EMAS**: have received funding in 2014/15 for a Research Paramedic. This post currently supports two NIHR Portfolio studies that do not report recruitment in the traditional way due to patient assent taken rather than consent. EMAS have four studies in the pipeline that are due to open this financial year. One of those studies, AIRWAYS II, may report report participant recruitment this financial year. 2. **LCHS**: this Trust supports several CRN Portfolio studies, however the consent event occurs in the primary care setting so the recruitment is attributed to Clinical Commissioning. There is scope for research within the community services (paediatrics, district nursing) that is being investigated, however it is unlikely that this Trust will report recruitment this financial year.	**99%**	**88% (red)**	**88% (red)**	**88%**

Expected date to meet standard / target	It is unlikely we will make the 99% target due to the nature of the services provided by LCHS. We may reach 94% by April 2015.
Revised date to meet standard	
Lead Director / Lead Officer	Elizabeth Moss, Chief Operating Officer CRN: East Midlands

RS6b Proportion of NHS Trusts recruiting each year into commercial NIHR CRN Portfolio studies

What is causing underperformance?	What actions have been taken to improve performance?	Target (mthly / end of year)	Latest month performance	YTD performance	Forecast performance for next reporting period
There are 16 Trusts within the East Midlands region, with 9 Trusts currently recruiting to commercial studies. The seven who have not reported any recruitment are: • East Midlands Ambulance Service NHS Trust (EMAS) • Derbyshire Community Health Services NHS Foundation Trust (DCHS) • Lincolnshire Community Health Services (LCHS) • Leicestershire Partnership NHS Trust (LePT) • Lincolnshire Partnership NHS Trust (LiPT) • Nottinghamshire Healthcare NHS Foundation Trust (NHFT) • Derbyshire Healthcare NHS Foundation Trust (DHFT)	1. **EMAS**: Currently no open commercial studies nationally run by ambulance services on the NIHR portfolio, therefore unlikely that EMAS will open a commercial study this financial year. Industry team currently reviewing studies previously run at other ambulance services across the country to gain insight. Meeting with Trust and RDM for Division 6 to discuss this month 2. **DCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research, Have met with Trust and a preliminary plan is in place to take this forward. 3. **LCHS**: due to the nature of research within this Trust, they are unlikely to be involved in commercial research. Met on the 18th December and a preliminary plan is in place to take this forward. 4. **LePT**: Selected for one study, due to open by the end of 2014. One study also being taken forward with sponsor and awaiting confirmation if selected 5. **LiPT**: have been involved in commercial research in the past and the site is actively seeking commercial opportunities 6. **NHFT**: One trial initiated at the end of November 2014, 2nd UK site to open 7. **DHFT**: One trial recently opened to recruitment closed early prior to recruitment. 2 studies in the pipeline.	**70%**	**56% (red)**	**56% (red)**	**56%**



Expected date to meet standard / target	April 2015
Revised date to meet standard	June 2015
Lead Director / Lead Officer	Daniel Kumar, Industry Delivery Manager, CRN: East Midlands

2014/15 NTDA METRICS AND WEIGHTINGS

Responsiveness Domain

Metric	Standard	Weighting
Referral to Treatment Admitted	90	10
Referral to TreatmentNon Admitted	95	5
Referral to Treatment Incomplete	92	5
Referral to Treatment Incomplete 52+ Week Waiters	0	5
Diagnostic waiting times	1	5
A&E All Types Monthly Performance	95	10
12 hour Trolley waits	0	10
Two Week Wait Standard	93	2
Breast Symptom Two Week Wait Standard	93	2
31 Day Standard	96	2
31 Day Subsequent Drug Standard	98	2
31 Day Subsequent Radiotherapy Standard	94	2
31 Day Subsequent Surgery Standard	94	2
62 Day Standard	85	5
62 Day Screening Standard	90	2
Urgent Ops Cancelled for 2nd time (Number)	0	2
Proportion of patients not treated within 28 days of last minute cancellation	0	2
Delayed Transfers of Care	3.5	5
TOTAL - 18 Indicators		78

Effectiveness Domain

Metric	Standard	Weighting
Hospital Standardised Mortality Ratio (DFI)		5
Deaths in Low Risk Conditions		5
Hospital Standardised Mortality Ratio - Weekday		5
Hospital Standardised Mortality Ratio - Weekend		5
Summary Hospital Mortality Indicator (HSCIC)		5
Emergency re-admissions within 30 days following an elective or emergency spell at the Trust		5
TOTAL - 6 Indicators		30

Safe Domain

Metric	Standard	Weighting
Clostridium Difficile - Variance from plan		10
MRSA bactaraemias	0	10
Never events	0	5
Serious Incidents rate	0	5
Patient safety incidents that are harmful		5
Medication errors causing serious harm	0	5
CAS alerts	0	2
Maternal deaths	1	2
VTE Risk Assessment	95	2
Percentage of Harm Free Care	92	5
TOTAL - 11 Indicators		51

Caring Domain

Metric	Standard	Weighting
Inpatient Scores from Friends and Family Test	60	5
A&E Scores from Friends and Family Test	46	5
Complaints		5
Mixed Sex Accommodation Breaches	0	2
Inpatient Survey Q 68 - Overall, I had a very poor/good experience		2
TOTAL - 5 Indicators		19

Well Led Domain

Metric	Standard	Weighting
Inpatients response rate from Friends and Family Test	30	2
A&E response rate from Friends and Family Test	20	2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place of work		2
NHS Staff Survey: Percentage of staff who would recommend the trust as a place to receive treatment		2
Data Quality of Returns to HSCIC		2
Trust turnover rate		3
Trust level total sickness rate		3
Total Trust vacancy rate		3
Temporary costs and overtime as % of total paybill		3
Percentage of staff with annual appraisal		3
TOTAL - 10 Indicators		25

CQC – Intelligent Monitoring Report

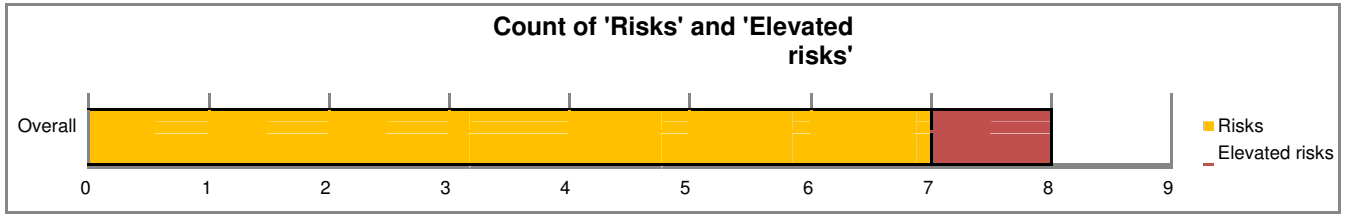
The latest CQC Intelligent Monitoring Report (IMR) was published on the CQC website on the 3rd December 2014.

The IMR evaluates against a range of indicators relating to the five key questions used by the CQC as part of their inspections - is the organisation safe, effective, caring, responsive, and well-led?

Within each area of questions a set of indicators has been developed and each indicator has then been analysed to identify the following levels of risk for each organisation:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

The next publication date is May 2015.



Priority banding for inspection	Recently inspected
Number of 'Risks'	7
Number of 'Elevated risks'	1
Overall Risk Score	9
Number of Applicable Indicators	94
Percentage Score	4.79%
Maximum Possible Risk Score	188

Elevated risk	Whistleblowing alerts (18-Jul-13 to 29-Sep-14)
Risk	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Mar-14)
Risk	Composite indicator: A&E waiting times more than 4 hours (01-Jul-14 to 30-Sep-14)
Risk	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Apr-14 to 30-Jun-14)
Risk	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)
Risk	TDA - Escalation score (01-Jun-14 to 30-Jun-14)
Risk	GMC - Enhanced monitoring (01-Mar-09 to 22-Jul-14)
Risk	Patient Opinion - the number of negative comments is high relative to positive comments (28-May-13 to 27-May-14)

Quality Schedule and CQUIN Schemes

Confirmed RAG's for Quarter 3 and predicted RAG's for Quarter.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
	QUALITY SCHEDULE					
PS01	Infection Prevention and Control Reduction. - C Diff	G	A	tbc	G	Q2 Amber RAG remains as Multi Drug Resistant data not submitted. Monthly reporting of C Diff. Threshold for 14/15 is 81. UHL is aiming to achieve a reduction on last year's total of 66 and has given itself a Target of 50 . 61 cases as at end of January which is below the NTDA trajectory but above UHL's own threshold. Q3 RAG to be confirmed at the March CQRG
PS02	HCAI Monitoring - MRSA	0	1	2	G	1 in October and 2 in December. All reviews to date confirm these were unavoidable. None reported in January.
PS03	Patient Safety – SIs, Never Events	G	G	2 tbc	1 G	Q3 & Q4 Red RAG for Never Events. (relating to 'wrong sized hip prosthesis, retained Swab ties and wrong site surgery Q3 Patient Safety Report due to be presented to the March CQRG. Number of incidents reported continues to rise. But there has been a reduction in number that resulted harm.
PS04	Duty of Candour	0	0	0	0	No breaches to date.
PS05	Complaints and user feedback Management (excluding patient surveys).	A	A	G	G	Complaints responses performance improved and achieved for December. Q3 RAG to be confirmed at the March CQRG.
PS06	Risk Assurance and CAS Alerts	A	A	G	G	Amber RAG for Q2 relates to overdue CAS alerts for July. All risk reviews back on track for Q3. No overdue CAS alerts and all risk reviews and actions on Track
PS07	Safeguarding – Adults and Children	G	G	G	G	Assurance documentation due to be sent to CCG Safeguarding leads for their review ahead of their observational visit to the Trust.
PS08	Reduction in Pressure Ulcer incidence.	G	G	R	G	Monthly thresholds met for G3 HAPUs. Above the monthly trajectory for Grade 2 HAPUs in both Nov (13) and Dec (11) and Grade 4. Within trajectory for both G2 and G3 for Jan and No Grade 4.
PS09	Medicines Management Optimisation	A	G	A	G	Commissioners noted improvement in Controlled Drugs audit report and also Medicines Code but thresholds not fully achieved. Progress made with developing LLR Medicines Optimisation Strategy.
PS10	Medication Errors	G	G	G	G	Increased reporting of errors and actions being taken.
PS11	Venous Thromboembolism (VTE) and RCAs of Hospital Acquired Thrombosis	95.7%	96.1%	G	G	Preliminary data suggested Dec performance below 95% for VTE risk assessment but case note review confirmed actual performance above 95% and Q3 performance overall = 95.6%. RCAs in progress for Q3 Hospital Acquired Thrombosis. RAG

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
PS12	Nutrition and Hydration	G	>80%	>85%	tbc	Work programme on track for nutrition, some delays with hydration actions. Threshold achieved for all measures across all CMGs with exception of ESM for 'Protected Mealtimes'.
PE1	Same Sex Accommodation Compliance and Annual Estates Monitoring	2	0	2	0	2 breaches in Q3. No breaches to date for Q4
PE2	Patient Experience, Equality and Listening to and Learning from Feedback.	G	G	tbc	G	Good progress made with triangulation of data. Waiting time main area for improvement. RAG tbc at March CQRG
PE3	Improving Patient Experience of Hospital Care (NPS)	N/A	N/A	N/A	tbc	Not due to be reported until March 15. RAG dependent upon results in the National Patient Survey.
PE4	Equality and Human Rights	G	G	G	G	Progress reported to the September CQRG with further information provided in October – relating to actions being taken to capture BME data
CE01	Communication – Content (ED, Discharge & Outpatient Letters)	A	A	tbc	G	Clinical Problem Solving Group held to agree key priorities. Letters policy finalised launched end of Jan 15. RAG tbc at March CQRG
CE02	Intra-operative Fluid Management	G	>80%	<80%	G	Performance deteriorated during Oct/Nov. 80% achieved for December. Remedial actions in place to maintain.
CE03	Clinical Effectiveness Assurance – NICE and Clinical Audit	A	A	G	G	Responses for NICE Clinical Guideline / Quality Standards documents on track and actions being taken where audits behind schedule
CE04	Women's Service Dashboard	A	A	tbc	tbc	Amber RAG for Q2 relates to increase in C Section Rate. Q3 RAG to be confirmed at the March CQRG
CE05	Children's Service Dashboard	A	A	tbc	tbc	Q2 Amber RAG relates to SpR training Q3 RAG to be confirmed at the March CQRG
CE06	Patient Reported and Clinical Outcomes (PROMs and Everyone Counts)	A	A	tbc	G	Groin Hernia PROMs improved, although still below the national average. Consultant Outcomes published and all consultants in line with national average. Q3 RAG to be confirmed at the March CQRG.
CE07	#NOF - Dashboard	51%	67.9%	62.1%	57.9	72% threshold not met for any month in Q3. Mainly relates to peaks in activity and spinal patients. Performance deteriorated for Jan. L*i*A programme in place and business case submitted to support increased theatre capacity.
CE08a	Stroke monitoring	G	G	A G	G	Red for '90% stay on Stroke Unit not achieved for Oct or for November TIA Clinic thresholds exceeded and improvements made for other Stroke indicators (time to Scan, admission to stroke unit, thrombolysis). SSNAP data for Q3 to be confirmed.
CE08 b	TIA monitoring	76%	67%	73.4%	80.6%	Threshold achieve for each month for high risk patients and performance improved for low risk patients being seen within 7 days.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
CE09	Mortality (SHMI, HSMR)	A	A	A	A	Latest published SHMI = 105 (104.7) and is slowly reducing but is still above 100.
CE10	Making Every Contact Count (MECC)	A	G	tbc	G	Referrals to STOP and ALW continue. 'Healthy Eating and Physical Activity publicity campaign due to commence in General Surgery and Sleep Clinics. Q3 RAG to be confirmed at March CQRG.
AS01	Cost Improvement Programme (CIP) Assurance	A	G	tbc	G	Q3 RAG revised upon review of additional assurance.
AS02	Ward Healthcheck (Nursing Establishment, Clinical Measures Scorecard)	G	G	G	G	Recruitment of additional nurses continues. Not all wards meeting 'Nurse to bed Ratio' but actions in place. Support being provided to those wards not meeting thresholds in the Clinical Measures Scorecard.
AS03	Staffing governance	A	A	A	A	Internal thresholds not met for Appraisal, Sickness and Corporate Induction or Turnover although improvement noticed. Medical Staffing Strategy submitted.
AS04	Involving employees in improving standards of care. (Whistleblowing)	G	G	G	G	Actions taken to address concerns raised.
AS05	Staff Satisfaction	G	G	G	G	
AS06	External Visits and Commissioner Quality Visits	G	G	G	G	Actions in response to Reviews being taken.
AS07	CQC Registration	A	G	A	G	2 Actions in response to CQC visit findings behind schedule – remedial actions being taken.
	NATIONAL CQUINS					
Nat 1.1a	F&FT 1a - Staff	G	G	G	G	Implemented during Q1/2. No Staff F&FT survey undertaken in Q3 as National Staff Survey.
Nat 1.1b	F&FT 1b - OutPt & Day Case	G	G	G	G	F&FT already happening in Day Case and has started in Outpatients.
Nat 1.2	F&FT 1.2 - Increased participation - ED	16.%	15.1%	16.2%	25.3%	Performance dropped significantly in November but up to 18.7% in December and YTD rate of 15.8% . Need to achieve 20% for Q4 to meet CQUIN requirements.
Nat 1.3	F&FT 1.3 - Inpt increase in March	35.8%	31%	34.7%	34.6%	Improvement in January and still on track to achieve Q4 30% threshold but need to further improve to achieve 40% for March 15 for additional CQUIN monies.
Nat 2.1	ST 2.1 - ST data submission	G	G	G	G	Data collection continues for all 4 harms.
Nat 2.2	ST 2.2 - LLR strategy	G	G	tbc	G	UHL contributing to the LLR Pressure Ulcer group and workstreams. Q3 RAG to be confirmed upon receipt of LLR Group minutes.

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
Nat 3.1	Dementia 3.1 - FAIR	G	G	G	G	90% thresholds met for all parts of the Dementia FAIR CQUIN.
Nat 3.2	Dementia 3.2 - Training & Leadership	G	N/A	N/A	G	Nicky Morgan is new Clinical Lead Dementia Training Programme reviewed and revised. Q4 RAG dependent on evidence of increased staff attending training.
Nat 3.3	Dementia 3.3 - Carers	G	G	G	G	Surveys carried out and evidence of actions being taken
	LOCAL CQUINS					
Loc 1	Urgent Care 1 (Discharge)	G	G	G	tbc	Although no improvement in 'discharges before 11am/1pm' in Q3, Commissioners' noted increased capacity issues and work undertaken in Q3.
Loc 2	Urgent Care 2 (Consultant Assessment)	G	G	A	tbc	65% threshold exceeded for AMU but not achieved in other assessment areas. Audit data not felt to accurately reflect practice. Q4 audit to have increased clinical input to ensure accuracy but unlikely to achieve the 75% threshold across all areas.
Loc 3	Improving End of Life Care (AMBER)	G	G	G	G	New facilitators in post and Q3 threshold achieved.
Loc 4	Quality Mark	G	G	G	A	Quality Mark achieved for 6 out of the 8 wards to date. Although remaining 2 wards on track to achieve the QM, will be outside the agreed timescale for Q4.
Loc 5	Pneumonia	A	G	G	G	Q3 threshold achieved for all aspects of CQUIN scheme.
Loc 6	Think Glucose	G	G	G	G	Think Glucose programme on track.
Loc 7	Sepsis Care pathway	≥47%	≥60%	A	G	Not all 6 aspects of the Sepsis6 Care Bundle thresholds achieved in Q3. Remedial actions in place for Q4.
Loc 8	Heart Failure	≥49.5 %	≥63%	≥65%	tbc	Q3 65% threshold achieve and actions on track. Q4 RAG dependent upon achievement of 75% threshold.
Loc 9	Medication Safety Thermometer	G	G	G	G	All wards submitting data.
	SPECIALISED CQUINS*					
SS1	National Quality Dashboards	G	G	G	G	Dashboards now open for data submission at end of Q3

Ref	Indicator Title	Q1 RAG	Q2 RAG	Q3 RAG	Q4 Predicted RAG	Commentary
SS2	Breast Feeding in Neonates	61%	66%	tbc	G	Threshold not fully achieved for Q3 with remedial actions in place.
SS3	Clinical Utilisation Review of Critical Care	N/A*	G	G	G	CCMDS and ICNARC data now being collected for all satellite HDUs.
SS4	Acuity Recording	N/A*	G	G	G	Acuity recording in place for all areas. Q4 RAG dependent upon being able to demonstrate effective use of Acuity data.
SS5	Critical Care Standards - Disch	N/A*	G	tbc	G	Reduction in delays but increase in out of hours transfers during December – related to increased activity in Critical Care.
SS6	Critical Care Outreach Team	N/A*	G	tbc	G	Q3 threshold not fully achieved. Remedial actions in place.
SS7	Consultant Assessment	G	G	tbc	tbc	Links to the CCG CQUIN.
SS8	Highly Specialised Services Collaborative Workshop	G	G	G	G	Q3 threshold is to provide update regarding participation in Clinical Benchmarking for both ECMO and PCO.